DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 27, 2019

Administrator
Essentia Health Virginia Care Center
901 9th Street North
Virginia, MN 55792

RE: Project Number H5458018C and H5458017C

Dear Administrator:

On February 15, 2019, an abbreviated standard survey was completed at your facility by the Minnesota Departments of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. At the time of the February 15, 2019 abbreviated survey the Minnesota Department of Health, completed an investigation of complaint numbers H5458018C and H5458017C that were substantiated.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is March 27, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- Civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 15, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 15, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245458	A. BUILDING _____ B. WING _____	C 02/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH VIRGINIA CARE CENT	**901 9TH STREET NORTH VIRGINIA, MN 55792**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted 2/14/19 to 2/15/19, to investigate complaints H5458018C and H5458017C. Essentia Health Virginia Care Center is not in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities for F609 and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 609		4/12/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/04/2019

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F 609	Continued From page 1 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report to the State Agency (SA) an injury of unknown origin within 2 hours if the event caused serious bodily injury or not later than 24 hours if the event did not involve abuse or result in serious bodily injury for 1 of 3 residents (R1) reviewed for abuse procedures. Findings include: R1's Face Sheet undated, indicated R1 had diagnoses that included dementia without behavioral disturbances, history of a stroke, diabetes, chronic anemia, chronic pain, and anxiety. R1's quarterly Minimum Data Set (MDS) dated 11/19/18, indicated R1 had severely impaired cognition, and was totally dependent on 2 staff for activities of daily living (ADLs). The MDS further indicated R1 did not walk, and had not fallen. R1's care plan dated 5/20/14, indicated she	F 609	The injury of unknown origin for R1 was reported to the State Agency and has since been resolved. All residents have the potential to be affected by not notifying the State Agency of an injury of unknown origin within the timeframe required by regulations. The Abuse, Neglect, Mistreatment and Misappropriation policy has been reviewed and revised as appropriate. Staff have been re-educated on the policy; and, specifically the necessity to report an injury of unknown origin in the timeframe required by the regulations. Daily for three months and then weekly the DON/Designee will review all bruise events in the EMR to ensure that there we no bruise events that were not appropriately and timely reported if needed. Issues will be brought immediately to the attention of the Administrator to address. Results of the review will be discussed at least quarterly	

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F 609	Continued From page 2 required a total assist of 2 staff and a mechanical lift for all transfers, and 2 staff for all bed mobility. The care plan further directed 2 staff to provide cares at all times including transfers and repositioning to ensure comfort; to ensure R1's legs were uncrossed when transferring with the mechanical lift in and out of bed, to use great care not to bump her legs or arms on the lift, and to have 2 staff at all times to transfer with a lift. The care plan also indicated to not seat R1 under the table for meals or when in the Aviary, but to place R1 next to the table as to ensure she was not able to bump herself on the underside of the table or on the legs or pedestal when she moved her legs. An undated nursing assistant care guide indicated R1 required a total assist of 2 staff at all times for cares and transfers. On 2/4/19, at 6:10 a.m. a progress note indicated R1 had a large bruise to the left upper shin (just below the knee) that was approximately 7.0 centimeters (cm) by 16.0 cm. The area was swollen, and the left knee was significantly swollen when compared to the right knee. The note further indicated the area was very painful to the resident, noted moderate pain on a scale for those who are non-verbal. Finally, the note indicated the night and day shift nursing assistants (NA)s did not notice the bruise the day before. On 2/4/19, at 7:19 a.m. a progress note indicated R1's left knee was slightly swollen, not hot to the touch, and R1 did not yell out when the area was touched. The note indicated the area below the knee was bruised, green and purple in color with no signs of pain when touched. The note further	F 609	at the QAPI meeting. Ongoing review will be at the recommendation of QAPI team.	

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F 609	Continued From page 3	F 609		

indicated R1 had a diagnosis of chronic anemia and she bruised easily due to low hemoglobin, and R1 had a tendency to cross her legs, and it appeared R1 bumped the area on the mechanical lift during transfers.

On 2/7/19, at 8:30 a.m. a progress note indicated the nurse practitioner was notified of the R1's left knee pain. The note indicated R1 received scheduled Norco (an opioid pain reliever) three times a day, and as needed (PRN)Tylenol which was not managing her pain.

On 2/7/19, at 10:04 a.m. a progress note indicated the nurse practitioner ordered an x-ray to R1's left patella (knee cap) and left femur.

On 2/7/19, at 12:07 p.m. a progress note indicated R1 was diagnosed with a left proximal tibial plateau fracture, non operative. Orders were to ice the knee 3-4 times daily for 15 minutes at a time; and increase Norco for pain relief.

R1's fractures were reported to the SA on 2/7/19, at 11:50 a.m.

On 2/15/19, at 9:08 a.m. the director of nursing (DON) stated in retrospect, the initial bruising on R1 was an injury of unknown origin and should have been reported at the time the initial bruising was noted. The DON stated the only likely cause of the fractures were from a transfer, but no one interviewed could reference an instance when it could have happened.

The facility's Safe Patient Handling Policy reviewed 4/18/18, directed staff to follow manufacture guidelines for use and that full-body lifts were to be used for residents that were

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F 609	Continued From page 4 non-weight bearing or have unpredictable weight bearing capacity and to report unusual individual responses to lift use or refusal to a supervisor. The facility's full-body lifts were Maxi-Move and the manufacturer's directions dated 2/14, indicated the Maxi-Move was designed for use by two caregivers in order to manage routine transfers to and from bed, chair, or wheelchair, as well as emergency lifts from the floor. The facility's Abuse, Neglect, Mistreatment and misappropriation of Resident Property policy dated 11/22/17, defined an injury of unknown origin as an injury that was not observed by any person or the source of the injury could not be explained by the resident and the injury was suspicious because of the extent of the injury or the location of the injury. The policy also indicated that reporting to the State Agency shall occur immediately, but not more than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		4/12/19

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F 610	Continued From page 5 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete and report investigative results within 5 days to the State Agency (SA) for 1 of 3 residents (R6) reviewed for abuse. Findings include: R6's Face Sheet undated, indicated diagnoses that included diabetes, dementia, anxiety, chronic pain, and dependence on wheelchair. R6's quarterly Minimum Data Set (MDS) dated 11/26/18, indicated R6 was sometimes understood by others and sometimes understood others, exhibited inattention and disorganized thinking (signs of delirium), had physical, verbal, and other behaviors not directed to others, and rejected cares 1- 3 days of the 7 day assessment period. The MDS further indicated R6 did not walk, and required extensive or total assistance for activities of daily living. R6's care plan revised on 12/21/18, indicated R6 required assitance with daily cares because of impaired cognition and impaired mobility. The care plan also indicated R6 exhibited verbal and physically aggressive behavioral symptoms, and occasional physically abusive behaviors, was often irritable, and disruptive. The care plan	F 610	The allegation for R6 was reported to the State Agency, the investigation has been completed and the issue has been resolved. All residents have the potential to be affected by not completing an investigation within the timeframe required by regulations. The Abuse, Neglect, Mistreatment and Misappropriation policy which includes a section on completing an investigation and the timeframe has been reviewed and revised as appropriate. Staff have been re-educated on the policy; and, specifically the necessity to complete the investigation in the timeframe required by the regulations. Daily for three months and then weekly the Administrator/Designee will review all events reported to the State Agency to ensure that there we no events that were not completed within the timeframe required by regulations. Issues will be brought immediately to the attention of the Campus Administrator to address. Results of the review will be discussed at least quarterly at the QAPI meeting. Ongoing review will be at the recommendation of QAPI team.	

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F 610	Continued From page 6	F 610		

directed staff to stop and try a task later, not forcing R6 to do the task.

On 7/27/18, at 8:41 a.m. the facility reported to the SA that a nursing assistant (NA) had observed another NA (the alleged perpetrator, AP) yell at R6, and grab her arm. This alleged event had occurred on 7/26/18, at 6:30 a.m., more than 24 hours prior. The alleged perpetrator was off work at the time of the initial report, and suspended for 21 days during the investigation. The facility's 5 day investigative report was submitted to the SA on 8/1/19, at 3:32 p.m., but indicated the investigation was not yet complete.

On 2/15/19, at 9:08 a.m. the director of nursing (DON) stated the facility had to re-educate all staff on the reporting process, as the NA that observed the alleged event did not immediately report, but was overheard discussing the incident with colleagues. The DON stated the licensed staff that overheard the NA's talking did report to the DON, and the DON then immediately reported to the SA. The DON stated the investigation was not completed within 5 days, and she knew it had to be complete within 5 days. The DON stated she knew the initial report was late, and she had all staff re-educated. The DON stated she did not substantiate the alleged verbal abuse, as it was a "he said-she said" situation, and the resident was not able to say what happened due to cognitive loss. The AP stated she was holding back R6's arm in an effort to not be hit, versus holding her abusively. Finally, the DON stated that the AP was on a close watch after being reinstated, but left employment at the facility very shortly after being reinstated.

Review of facility re-education verified all staff

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F 610	Continued From page 7 were re-educated on immediately reporting alleged abuse. The facility's Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy, dated 11/22/17, indicated employees must always report any abuse or suspicion of abuse immediately to the administrator. The policy also indicated that initial reporting of allegation s was to occur immediately, or within 24 hours to the SA and the follow-up investigation would be submitted to the SA within 5 working days.	F 610		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 27, 2019

Administrator
Essentia Health Virginia Care Center
901 9th Street North
Virginia, MN 55792

Re: State Nursing Home Licensing Orders - Complaint Number H5458018C and H5458017C

Dear Administrator:

A complaint investigation was completed on February 15, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the licensing order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited violation. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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ESSENTIA HEALTH VIRGINIA CARE CENT	901 9TH STREET NORTH VIRGINIA, MN 55792

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaints #HH5458018C and H5458017C. As a result the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to Terri Ament Duluth Supervisor,	2 000		

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	00603	A. BUILDING: _____ B. WING _____	C 02/15/2019

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2 000	Continued From page 1 Minnesota Department of Health, 11 East Superior Street, Suite 290, Duluth, MN 55802	2 000		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause	21980		4/12/19

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21980	Continued From page 2 (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report to the State Agency (SA) an injury of unknown origin within 2 hours if the event caused serious bodily injury or not later than 24 hours if the event did not involve abuse or result in serious bodily injury for 1 of 3 residents (R1) reviewed for abuse procedures. Findings include: R1's Face Sheet undated, indicated R1 had diagnoses that included dementia without behavioral disturbances, history of a stroke, diabetes, chronic anemia, chronic pain, and anxiety. R1's quarterly Minimum Data Set (MDS) dated 11/19/18, indicated R1 had severely impaired cognition, and was totally dependent on 2 staff for activities of daily living (ADLs). The MDS further indicated R1 did not walk, and had not fallen.	21980	The injury of unknown origin for R1 was reported to the State Agency and has since been resolved. All residents have the potential to be affected by not notifying the State Agency of an injury of unknown origin within the timeframe required by regulations. The Abuse, Neglect, Mistreatment and Misappropriation policy has been reviewed and revised as appropriate. Staff have been re-educated on the policy; and, specifically the necessity to report an injury of unknown origin in the timeframe required by the regulations. Daily for three months and then weekly the DON/Designee will review all bruise events in the EMR to ensure that there we no bruise events that were not appropriately and timely reported if needed. Issues will be brought immediately to the attention of the Administrator to address. Results of the	

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21980	Continued From page 3 R1's care plan dated 5/20/14, indicated she required a total assist of 2 staff and a mechanical lift for all transfers, and 2 staff for all bed mobility. The care plan further directed 2 staff to provide cares at all times including transfers and repositioning to ensure comfort; to ensure R1's legs were uncrossed when transferring with the mechanical lift in and out of bed, to use great care not to bump her legs or arms on the lift, and to have 2 staff at all times to transfer with a lift. The care plan also indicated to not seat R1 under the table for meals or when in the Aviary, but to place R1 next to the table as to ensure she was not able to bump herself on the underside of the table or on the legs or pedestal when she moved her legs. An undated nursing assistant care guide indicated R1 required a total assist of 2 staff at all times for cares and transfers. On 2/4/19, at 6:10 a.m. a progress note indicated R1 had a large bruise to the left upper shin (just below the knee) that was approximately 7.0 centimeters (cm) by 16.0 cm. The area was swollen, and the left knee was significantly swollen when compared to the right knee. The note further indicated the area was very painful to the resident, noted moderate pain on a scale for those who are non-verbal. Finally, the note indicated the night and day shift nursing assistants (NA)s did not notice the bruise the day before. On 2/4/19, at 7:19 a.m. a progress note indicated R1's left knee was slightly swollen, not hot to the touch, and R1 did not yell out when the area was touched. The note indicated the area below the knee was bruised, green and purple in color with no signs of pain when touched. The note further	21980	review will be discussed at least quarterly at the QAPI meeting. Ongoing review will be at the recommendation of QAPI team.	

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21980	Continued From page 4	21980		

indicated R1 had a diagnosis of chronic anemia and she bruised easily due to low hemoglobin, and R1 had a tendency to cross her legs, and it appeared R1 bumped the area on the mechanical lift during transfers.

On 2/7/19, at 8:30 a.m. a progress note indicated the nurse practitioner was notified of the R1's left knee pain. The note indicated R1 received scheduled Norco (an opioid pain reliever) three times a day, and as needed (PRN)Tylenol which was not managing her pain.

On 2/7/19, at 10:04 a.m. a progress note indicated the nurse practitioner ordered an x-ray to R1's left patella (knee cap) and left femur.

On 2/7/19, at 12:07 p.m. a progress note indicated R1 was diagnosed with a left proximal tibial plateau fracture, non operative. Orders were to ice the knee 3-4 times daily for 15 minutes at a time; and increase Norco for pain relief.

R1's fractures were reported to the SA on 2/7/19, at 11:50 a.m.

On 2/15/19, at 9:08 a.m. the director of nursing (DON) stated in retrospect, the initial bruising on R1 was an injury of unknown origin and should have been reported at the time the initial bruising was noted. The DON stated the only likely cause of the fractures were from a transfer, but no one interviewed could reference an instance when it could have happened.

The facility's Safe Patient Handling Policy reviewed 4/18/18, directed staff to follow manufacture guidelines for use and that full-body lifts were to be used for residents that were non-weight bearing or have unpredictable weight

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21980	Continued From page 5 bearing capacity and to report unusual individual responses to lift use or refusal to a supervisor. The facility's full-body lifts were Maxi-Move and the manufacturer's directions dated 2/14, indicated the Maxi-Move was designed for use by two caregivers in order to manage routine transfers to and from bed, chair, or wheelchair, as well as emergency lifts from the floor. The facility's Abuse, Neglect, Mistreatment and misappropriation of Resident Property policy dated 11/22/17, defined an injury of unknown origin as an injury that was not observed by any person or the source of the injury could not be explained by the resident and the injury was suspicious because of the extent of the injury or the location of the injury. The policy also indicated that reporting to the State Agency shall occur immediately, but not more than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. Suggested Method of Correction: The Adminstrator and/or designee could review the facility polices in regards to reporting of allegations of mistreatment and/or injuries of unknown origin to the State Agency. The administrator and/or designee could educate staff on ensuring reports are submitted in a timely manner. The administrator or designee could routinely monitor to ensure reports are submitted in a timely manner. TIMELINE FOR CORRECTION: TWENTY-ONE DAYS	21980		